# POLK COUNTY CONTINUUM OF CARE

# CENTRALIZED INTAKE SYSTEM FOR HOMELESS ASSISTANCE

## POLICIES AND PROCEDURES

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OVERVIEW

PURPOSE
In establishing a Centralized Intake System, the Polk County Continuum of Care seeks to provide a single “front door” for homeless individuals and families seeking shelter and assistance. The system will include common intake, assessment and prioritization tools and process, referrals and placement decisions based on client needs, inventory of resources for housing and services, and consistent opportunities for prevention or diversion to appropriate resources, supportive services and permanent housing. When situations require emergency shelter, the Centralized Intake will employ rapid rehousing resources to minimize the trauma of homelessness and achieve stable housing as quickly as possible.

Additional expected benefits of the Centralized Intake System include:

- Creation of a common language and message from the homeless assistance system.
- Elimination of multiple triages, intakes and referrals for clients to multiple shelters and/or housing.
- Creation of a single voice for available beds for shelters and housing.
- Demonstration of efficiencies in matching homeless clients with appropriate community resources.

MEASURABLE OUTCOMES
The Centralized Intake system is expected to work towards measurable outcomes that will be set by the Performance Committee of the Polk County Continuum of Care (CoC). The Performance Committee will periodically review the measures to determine if any changes need to be made. If so the Committee will make recommendations to the CoC Board.

GUIDING PRINCIPLES
The primary goal of the Centralized Intake System is effective allocation of assistance and easy accessibility no matter where or how people present. The Centralized Intake System will assist the Polk County Continuum of Care in prioritizing assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. The centralized intake is also Housing First oriented, such that people are housed quickly without preconditions or service participation requirements.

The Polk County Continuum of Care Board (CoCB) has developed the following guiding principles for the operation of the Centralized Intake System:

- Right resources – Right time
- Client centered
- Prevent and divert when possible
- Real-time data and inventory
- Sustainable system: continuous evaluation and redesign as needed
The CoC will operate a Centralized Intake System that permits recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. Nondiscrimination and equal opportunity provisions include the following:

- Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability or familial status
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal assistance.
- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance.
- Title II of the Americans with Disabilities Act prohibits public entities, which includes State and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance.
- Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which includes shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

CENTRALIZED INTAKE SYSTEM

DESIGNATED OPERATING AGENCY

POLICY:
1.) Through a Request for Proposals process, the Polk County Continuum of Care Board will select an organization to operate the Centralized Intake System (CI).
2.) The selected organization will be required to enter into a Memorandum of Understanding with the Continuum of Care Board.

PROCEDURE:
1.) An initial Request for Proposals was released on August 30, 2013 with a proposal submission deadline of September 23, 2013.
2.) Submissions to the RFP were reviewed by the Centralized Intake Committee, which made a recommendation to the Continuum of Care Board for discussion and approval.
   2.1. On November 18, 2013, Centralized Intake Committee recommended that the Centralized Intake Provider be awarded the contract to be the central intakes provider. The recommendation was approved by the Polk County CoCB.
3.) Subsequent contracts will be considered on an annual basis with final determination being made through the process described above.
COMMUNITY EDUCATION AND MARKETING

POLICY:
Community education and marketing strategies will be designed to ensure that the centralized intake system includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth and those fleeing domestic violence. Materials will include statements that ensure access points that are accessible to individuals with disabilities.

PROCEDURE:
Community education and marketing strategies shall include the following:
1.) Informational flyers shall be developed and distributed agencies within the continuum, meal sites and food pantries as well as public locations such as libraries, DART station, bus depot and hospital emergency rooms.
2.) Announcements and presentations shall be made at community meetings such as CoCB, Directors Council and Service Council meetings.
3.) Programs to educate mainstream service providers and public schools will be provided.
4.) In adherence with CoC interim rule at 24 CFR 578.93(c), along with any CoC-funded program, CI will affirmatively market the system to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach and maintain records of those marketing activities.
5.) All housing assisted by or as a result of CI must be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2).

SYSTEM ENTRY

POLICY:
Entry into the Polk County Continuum of Care’s CI shall reflect the following characteristics:
1.) Full Coverage
   1.1 CI must offer full coverage of the CoC’s geographic area.
   1.2 CI must offer the same assessment approach at all access points
   1.3 CI must be useable by all people who may be experiencing homelessness or at-risk of homelessness.
   1.4 CI provides the same assessment approach, including standardized decision-making, at all access points.
2.) Fair and Equal Access

2.1 All people in the CoC’s geographic area have fair and equal access to the coordinated entry process, regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status as well as where or how they present for services.

2.2 People in all populations and subpopulations in the CoC’s geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence are assured to have fair and equal access to the CI process.

2.3 Fair and equal access means that people can easily access the coordinated entry process, whether in person, by phone, or some other method, and that the process for accessing help is well known.

2.4 If the entry point includes one or more physical locations, they are accessible to people with disabilities, and easily accessible by public transportation, or there is another method by which people can easily access them.

2.5 The coordinated entry process is able to serve people who speak languages commonly spoken in the community and takes reasonable steps to offer CI materials and participant instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency.

2.6 Efforts will be taken to ensure effective communication with individuals with disabilities including the provision of appropriate auxiliary aids and services necessary to ensure effective community (e.g. Braille, large type, assistive listening devices, and sign language interpreters. A list of resources to call will be at hand.

3.) Safety Planning

3.1 The coordinated entry process has protocols in place to ensure the safety of the individuals seeking assistance.

3.2 The protocols ensure that people fleeing or attempting to flee domestic violence and victims of domestic violence have safe and confidential access to the coordinated entry process and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelter.

3.2.1 All data collection must adhere to the Violence Against Women Act (VAWA).

3.2.2 Victim service providers funded by CoC and ESG program funds are not required to use the CoC’s CI process but are allowed to do so.

4.) Access to Emergency Services

4.1 The coordinated entry process does not delay access to emergency services, including all domestic violence and emergency services hotlines, drop-in service programs, and emergency shelters, including domestic violence shelters and other short-term crisis residential programs, to operate with as few barriers to entry as possible.
4.2 Access points provide connections to mainstream and community-based emergency assistance services such as supplemental food assistance programs and applications for income assistance.

4.3 The process includes a method for people to access emergency services at all hours independent of the operating hours of the coordinated entry intake and assessment processes.

5.) Outreach
5.1 The coordinated entry process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the coordinated entry process.

5.2 All participating street outreach staff, regardless of funding source, ensure that persons encountered by street outreach workers are referred to the organization contracted to implement CI so that they are offered the same standardized process as persons who access CI through site-based access points.

6.) Low Barrier
6.1 The coordinated entry process does not screen people out for assistance because of perceived barriers to housing or services, including but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record.

PROCEDURE:

1.) All subpopulations including chronically homeless families and individuals, Veterans, youth, individuals, and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault or stalking and transgendered persons shall be provided access to all components of the Centralized Intake System for which they are eligible independent of the characteristics and attributes of their specific subpopulations.

2.) The staff composition of the organization to operate the Centralized Intake System will include a program manager, intake staff, and case managers sufficient to effectively maintain high standards of implementation but within resources allocated by the community through the CoCB.

2.1 Duties of the program manager include but are not limited to being responsible for overall supervision of the Centralized Intake System; providing quality control oversight to insure intake information is correctly entered into ServicePoint and the referrals for services and housing the needs of the households requesting assistance; facilitating weekly meetings of intake worker and case managers and monthly case reviews; assisting in the triage of households with complex housing needs. The program manager will continually identify ways to improve the system for the benefit of the population being served.
2.2 The CI case managers will be responsible for completing on-site intakes, and community-based intakes when outreach staff is not available; making referrals for prevention/diversion services, housing interventions and shelter; provide transportation to housing and shelter interviews; and assist with telephone intakes as needed. The intake worker will be responsible for staffing the CI phone line and returning calls left on the CI voicemail.

3.) Entry into the centralized intake system will either be by phone or in person at CoC’s contracted CI providers’ outreach center. The physical location of the outreach center is accessible by four DART buses and is handicap accessible. To prevent language from being a barrier to accessing the centralized intake, persons who are non-English speaking will be assisted in one of two ways.

3.1 If the person speaks Spanish, a bilingual staff person at the contracted CI provider will assist the intake worker with completing the intake.

3.2 If the person speaks a language other than Spanish, the intake worker will use the Language Line services to communicate with the person.

3.3 CI provider will maintain a contact list of other resources so that barriers to communication are eliminated to the extent that resources can be identified.

4.) Persons experiencing homelessness will also be engaged to enter the centralized intake system, by partnering area homeless outreach teams. System entry for persons engaged by identified outreach teams may be entered on the spot with use of hand held tablets or by transporting the person to the contracted CI provider’s outreach center. These same system entry options shall be available to persons engaged by additional partnering outreach teams by the respective team making a referral to either designated outreach team or directly to the CI location.

5.) All agencies participating in the Centralized Intake System who are contacted by a person or their representative seeking homelessness assistance services, shall provide the centralized intake number and/or directions to the operating organization’s outreach center. Two exceptions to this rule are:

5.1 Individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking. To insure the continued safety and privacy of victims of domestic violence, the individual seeking services will be given a choice about potential referral to Children and Families of Iowa’s (CFI) domestic violence services. CFI will be the central point of contact for victims of domestic violence for individuals who make that choice. If centralized intake staff or outreach workers engage a person(s) self-identifying as needing domestic violence services, the worker will immediately contact CFI’s domestic violence program. If necessary, CFI shall provide transportation to the domestic violence shelter. If CFI’s domestic violence program is full, CFI and CI staff shall work together to identify and transport the household to another area domestic violence shelter.

5.2 Persons presenting at Central Iowa Shelter & Services (CISS). In keeping with the Guiding Principle of the Centralized Intake System being “client-centered”,
individuals presenting at CISS will be immediately accepted into shelter with follow-up assessment occurring at a later date by the CI staff either on-site or at the CI intake location.

6.) Centralized Intake will receive calls and take walk-in referrals from 8am-5pm, Monday through Friday. In instances where the intake worker is on the phone and the case managers are engaged with other clients, the caller will be transferred to an answering machine that will convey a message providing directions for leaving a message or stopping by the outreach center for an intake. The answering machine shall be checked by the intake worker as soon as he/she has completed a call.

6.1 Calls received from families after 5pm on weekdays, or anytime on weekends, will be referred to 211 to determine potential eligibility for an overnight or weekend motel stay.

6.2 Calls from single individuals or couples without children received after 5pm on weekdays, or anytime on weekends, will be referred to Central Iowa Shelter & Services.

7.) If individuals or families require transportation to the centralized intake access point, the CI provider will arrange for transportation. If necessary CI caseworkers or identified outreach workers will go to the caller and complete the intake at the caller’s location.

INTIAL INTAKE AND ASSESSMENT

POLICY:
All methods of system entry (i.e., phone, in-person, and tablet by outreach teams) shall offer the same standardized, assessment tool and referrals using uniform decision-making processes in order to achieve fair, equitable, and equal access to services within the community. The CI system is prohibited from screening people out of the process due to perceived barriers to housing or services, including, but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

To ensure an effective assessment process, the assessment tool shall reflect the following principles:

1.) Phased Assessment
   1.1 The assessment tool will employ a series of situational assessments that allow the assessment process to occur overtime and only as necessary.
   1.2 The successive assessments shall build on each other so a person does not have to repeat their story.

2.) Necessary Information
2.1 The assessment process only seeks information necessary to determine the severity of need and eligibility for housing and services and is based on evidence of the risk of becoming or remaining homeless.

3.) Participant Autonomy
   3.1 The protocol for filling out assessment tools provides people receiving the assessment the opportunity to refuse to answer questions without retribution or limitation to their access to assistance.

4.) Person-centered
   4.1 The assessment process provides options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need.
   4.2 The process also incorporates participants’ strengths, goals, and protective factors to recommend options that best meet the needs and goals of the people being assessed.
   4.3 Participants must be informed of their right to file a complaint using the participant rights form.

5.) Cultural Competence
   5.1 Staff administering assessments use culturally competent practices, and tools containing culturally competent questions and offer options and recommendations that reflect the population’s specific needs.

6.) User-friendly
   6.1 Tools are brief, easily administered by non-clinical staff including outreach workers, minimize the time required to utilize, and are easy for those being assessed to understand.

7.) Privacy Protections
   7.1 Privacy protections are in place to ensure proper consent and use of client information.

8.) Meaningful Recommendations
   8.1 Tools are designed to collect the information necessary to make meaningful recommendations and referrals to available housing and services.
   8.2 Participants being assessed should know exactly to what program they are being referred, what will be expected of them, and what they should expect from the program.
   8.3 The Centralized Intake process should avoid placing people on long waiting lists.

9.) Sensitive to Lived Experiences
   9.1 The tool’s questions are worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness.
   9.2 The tool minimizes risk and harm, and provides individuals or families with the option to refuse to answer questions.
9.3 Agencies administering the assessment have and follow protocols to address any psychological impacts caused by the assessment and administer the assessment in a private space, preferably a room with a door, or, if outside, away from others’ earshot.

9.4 Those administering the tool are trained to recognize signs of trauma or anxiety.

10. The CoC may use Homeless Management Information Systems (HMIS) to collect and manage data associated with assessments and referrals.

11. CoC along with CI contractor provides training opportunities at least once annually to organizations and or staff persons at organizations that serve as access points or administer assessments. CoC updates and distributes training protocols at least annually. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to CoC’s coordinated entry written policies and procedures. Training curricula include the following:

11.1 Review of the CoC’s written CI policies and procedures, including any adopted variations for specific subpopulations

11.2 Adherence to the stipulations within both the HMIS Confidentiality and Responsibility Certification as well as the Polk County Coordinated Intake Network Memorandum of Understanding and Interagency Data Sharing & Coordinated Services Agreement documents.

11.3 Requirements for use of assessment information to determine prioritization

11.4 Criteria for uniform decision-making and referrals

11.5 All assessment staff are trained on safety planning and other next step procedures if safety issues are identified in the process of participant assessment.

PROCEDURE:
The intent of the ServicePoint-based initial intake and assessment process is a.) To gather pertinent information necessary to identify persons who are literally homeless, or in need of diversion or prevention assistance; b.) To match appropriate levels of housing and services to the individual’s or family’s needs; and c.) To prioritize the referral to housing and services to insure those individuals and families with the greatest need are served first.

1. The initial Intake and Assessment will be completed with persons calling or walking into the Centralized Intake System administering organization’s outreach center as well as with adults and youth who are engaged by the administrative organization’s homeless outreach teams.

1.1 Identified staff shall be trained in asking appropriately worded questions reflecting their understanding of the culture of the person seeking assistance and to avoid causing the person to relive difficult experiences.

1.2 Outreach staff will offer adults and youth with whom they engage the option to return to the administering organization’s outreach center to complete the initial intake and assessment, or will complete it on the spot using a hand-held tablet.
1.3 For families who enter shelter after hours or on the weekend, a centralized intake staff person will go to the shelter the next business day, and complete the initial intake and assessment.

1.4 The initial intake and assessment shall be completed in a private setting that maintains the confidentiality of the person seeking assistance and prevents the person’s answers from being overheard. If the initial intake and assessment is completed in the field, precautions will be taken to ensure the necessary distance from others is observed to maintain the privacy of the person seeking assistance.

2.) Prior to beginning the initial intake and assessment, the person seeking assistance will be given the option to sign a Release of Information (ROI) – Appendix A - as well as informed that they may choose to not answer any question asked during the initial intake and assessment process.

2.1 The information gathered in the initial intake process will not be shared with the participating CI Network agencies (Appendix B) if the person seeking assistance does not wish to sign the ROI.

2.2 Each person seeking assistance will be assured that they will not be denied assistance should they refuse to sign the ROI or answer specific questions.

Initial Intake

1.) The Initial Intake is comprised of four phases: Prescreening, a Shelter Screen, a Diversion Screen and a Prevention Screen.

1.1 The four phases of the Initial Intake build on each other, and are accessible to the case management staff of participating CI Network agencies in the continuum, to prevent the person seeking assistance from having to repeat their story.

1.2 A person seeking assistance will only have to answer the questions for a particular “screen” based on their specific need for assistance.

1.3 The questions in each phase are brief and request rudimentary information to ensure ease of understanding by the person seeking assistance and, cultural competence and to minimize the risk of re-traumatizing the person.

Prescreening Questions

Each household who walks in or contacts CI shall be asked a series of prescreening questions to determine if their immediate personal safety is threatened or if they should go through the centralized intake process.

1.) Personal safety prescreen questions include:

- Are you fleeing from domestic violence?
- Are you in immediate danger?
- Do you have urgent health issues – bleeding, trauma, chest pains, nausea, etc.?
- Acute suicidal/homicidal/medical issues?

1.1 Persons fleeing domestic violence will be referred to CFI’s domestic violence
services. No information about the person will be entered into the Initial Intake and Assessment. If legal assistance is needed the person will be referred to Iowa Legal Aid by CFI’s domestic violence service.

1.2 Persons who are in immediate danger, have urgent health issues or have acute issues will be further assessed for immediate intervention by police and/or medical personnel. If needed, 9-1-1 will be called.

2.) Current living situation
A series of prescreen questions shall be asked to gather information about the size of the household and the household’s current living situation.

2.1 If the household is “literally homeless” or at “imminent risk of homelessness”, the intake worker will continue on to the Shelter Screening.

2.2 If not, the intake worker shall continue with the next series of prescreening questions to gather information about the households eviction and utility arrears history, whether the household can stay where they stayed last night and under what conditions, and if the lease is in the caller’s name.

2.21 If the lease is in the caller’s name, the intake worker will continue on to the Prevention Screening.

2.22 If the lease is not in the caller’s name, the intake worker will continue with the next series questions which constitute the Diversion Screening.

Shelter Screening

1.) The Shelter Screening will assess any unique housing barriers (e.g., restrictions on where the household can live, parole/probation, “No Contact” orders, sex offender registry), the household’s past shelter history, any physical or mobility issues to be considered for shelter placement and any supports the household currently has in place.

1.1 Physical or mobility issues as well as individual disabilities shall be recorded in the Polk County Disability Detail Assessment.

1.2 Following the completion of the Shelter Screening, the intake worker shall complete a VI-F-SPDT with the family.

1.3 If shelters are full and/or there are families with lower VI-F-SPDAT scores, the CI provider will work with the family on prevention/diversion options, coordinate with Polk County General Assistance and communicate with shelters about possible openings for family placement. The CI provider will look at all possible safe housing options for a family.

Households that are successfully referred to shelter will end their engagement with CI.

The intake worker shall complete the Centralized Intake Disposition noting the continuum project to which the household was referred and the assessment disposition.
**Prevention Screen**

1.) The Prevention Screen will assess any unique housing barriers (i.e., restrictions on where the household can live, parole/probation, “No Contact” orders, sex offender registry), the households past shelter history, any physical or mobility issues to be considered for shelter placement and any supports the household currently has in place.

2.) Physical or mobility issues as well as individual disabilities shall be recorded in the Polk County Disability Detail Assessment.

3.) Households that are eligible for prevention shall be assigned to a centralized intake case manager who will refer the household to services such as rent or utility assistance, dispute mediation, legal assistance, or other resources needed to remain in their current housing.

4.) The CI provider will utilize the information from the Prevention Screen to assess whether the household is eligible for any prevention services.

   4.1 If prevention programs are available, the household will be referred based on the program criteria.

   4.2 If no prevention programs are available, the household will be referred to Iowa Legal Aid and/or Home Inc. for prevention services.

   4.3 Upon request, individuals or families will also be given a community resource guide.

Households that are referred to prevention services will end their engagement with the CI. The case manager shall complete the Coordinated Intake Disposition noting the continuum project to which the household was referred and the assessment disposition.

**Diversion Screen**

1.) The Diversion Screen assesses if the household can stay with the person/family where they are currently living or if there is some place else they could stay as well as and what it would take to stay with the person/family.

2.) Households that are eligible for diversion shall be assigned to a CI case manager.

   Assistance offered by the case manager may include dispute resolution, resources to contribute to the operation of the household such as groceries, financial assistance to repair a vehicle needed for employment, or rent/utility assistance so the household can move into their own housing, and referral to mainstream resources the household has not accessed.

3.) The CI provider will utilize the information from the Diversion Screen to assess if the household is eligible for any prevention services.

   3.1 If prevention programs are available, the household will be referred based on the program criteria.
3.2 Households will also be given a community resource guide with different agencies that may be able to assist with financial assistance.

Households that are successfully referred to diversion services will end their engagement with the centralized intake.

The case manager shall complete the Coordinated Intake Disposition noting the continuum project to which the household was referred and the assessment disposition.

Assessment Process

**VI-SPDAT**

1.) The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-F-SPDAT and VI-SPDAT) 2.0 will be administered to both families and individuals, respectively, to assess various health and social needs and then match them to the most appropriate housing interventions available (e.g., permanent supportive housing, rapid re-housing or affordable housing).

1.1 The VI-F-SPDAT and VI-SPDAT have a built-in scoring mechanism that will prioritize the family or individual for referral to the different housing interventions.

2.) The VI-F-SPDAT will be administered to families following the completion of the Initial Intake.

3.) The VI-SPDAT will also be administered to individuals and youth (18 years of age and older) following the completion of the Initial Intake, with the exception of individuals presenting at Central Iowa Shelter & Services (CISS). Youth having reached the age of 16 ½ and up to their 18th birthday will have the VI-SPDAT administered by Iowa Homeless Youth Centers.

4.) Within eight days of entering CISS, the CI case manager will administer the Initial Intake and VI-SPDAT to individuals presenting at CISS with any one of the following characteristics:
   - Mental health diagnosis
   - Veteran status
   - Chronic homeless
   - Age 55 or older
   - < 21 years of age
   - In shelter a second time in a year
   - No income

5.) Within three days of entering shelter, the CI case manager will administer the Initial Intake and VI-SPDAT to individuals presenting at CISS who have a severe mental health diagnosis and/or cannot complete activities of daily living.
6.) The CI case manager will administer the Initial Intake and VI-SPDAT to all non-flagged individuals who self-engage with the case manager.

**Comprehensive Assessment**

1.) Within seven days of entering family shelter, the shelter case manager shall complete the ServicePoint-based Comprehensive Assessment.

2.) The Comprehensive Assessment gathers more in depth information to assist the families in achieving their goals in the areas of mainstream resources (cash and non-cash benefits), employment, housing, child care and enrollment of children into school.

3.) Results of the comprehensive assessment as well as the client’s strengths, goals, and protective factors will be used to establish their housing and income goals.

**BASIS FOR REFERRAL**

**POLICY:**

1.) Referral to projects

The coordinated entry process makes referrals to:

1.1 All projects receiving Emergency Solutions Grants (ESG) and Continuum of Care (CoC) Program funds, including emergency shelter, Rapid Rehousing, Permanent Supportive Housing, and transitional housing (TH), as well as other housing and homelessness projects.

1.1.1 CoC Program and ESG-Program funded projects are required to participate in the Centralized Intake as the only source from which to consider filling vacancies in housing and/or services funded by CoC and ESG programs and to accept those referrals except on rare occasions (See Referral Rejection Policy)

1.2 Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals, while other housing and services projects determine the extent to which they rely on referrals from the coordinated entry process.

**PROCEDURE:**

1.) Referrals to housing, shelter and services will be made based on the following:

- Results of the Initial Intake
- Chronic homeless status
- Most severe service needs (VI-SPDAT/VI-F-SPDAT)
- Veterans status
- Degree of vulnerability
- Availability of a housing unit by program type (i.e., PSH, RRH or AH), size of priority list by program type and unit size
2.) The Centralized Intake program manager or designated staff will regularly check the availability of housing units with ESG and HUD CoC-funded housing programs, as well as other housing intervention stakeholders in the continuum accepting referrals through the CI.

2.1 These programs will notify the program manager, as soon as they receive funding for new housing units, of the approximate time they will begin accepting referrals for the new units. The program manager will use this information to keep an up-to-date inventory of available housing intervention resources.

3.) The real-time, daily inventory of family shelter beds will be kept by using the ServicePoint-based Polk County Shelter Registry.

3.1 On each line of the registry, shelter staff will record the entry date, shelter name, number of beds occupied by the family and the family’s name (using the Client ID # ONLY).

3.2 Shelter staff will communicate an expected opening by placing a comment in the “Notes” section when they are aware when a family will be exiting.

PRIORITIZATION FOR REFERRAL

POLICY:

1.) HUD has determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC.

2.) HUD’s policy is that people experiencing chronic homelessness should be prioritized for permanent supportive housing.

3.) In addition to prioritizing people experiencing chronic homelessness, the coordinated entry prioritizes people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness.

4.) Communities should take care to ensure that their prioritization process does not allow people who are more vulnerable or who have more severe service needs to languish in shelters or on the streets because more intensive types of assistance are not available.

4.1 This means that if a person is assessed as being highly vulnerable, that person may be prioritized for PSH, but if PSH is not available or the PSH has a long
waiting list, that person should be prioritized for other types of assistance such as RRH or TH. CoC’s should not assume that because a person is prioritized for one type of assistance, they could not be served well by another type of assistance.

4.1.1 CoCs should be aware that placing a household in transitional housing can affect their eligibility for other programs (e.g. lose eligibility for RRH and affect chronic homeless status).

5.) The priority list report is compiled from data existing in the HMIS. There are three methods to cause a client to appear on the priority list report.

5.1 Any client who has an active entry in an emergency shelter project will be included on the report.

5.2 Any client who has an active entry in a project designed to count unsheltered clients will be included on the report.

5.3 Any client who has an active entry in a project for clients staying at a non-HMIS shelter who also has an evaluation with Centralized Intake will be included in the report. The central intake agency will record the entries for clients who are 1) checked in to a non-HMIS shelter and 2) follow up for evaluation with Centralized Intake.

6.) Process for removing clients from the priority list:

6.1 Because the priority list is based on active records for clients in a shelter or unsheltered project, when a client is exited from an eligible project they will automatically drop from the report.

7.) The Centralized Intake agency will make referrals from the list based on criteria stated in the policy and procedure document.

7.1 When a referral is made, the referral will be recorded in HMIS.

7.2 The agency to which the client is referred will record the outcome of the referral.

7.3 Reports will be compiled of referral and referral outcome statistics.

8.) Many clients who have at one point appeared on the priority list will not be referred on to another project for a variety of reasons including: exiting from shelter on their own, disappearing from shelter, or becoming unable to locate.

PROCEDURE:

1.) A priority list shall be maintained by the centralized intake staff for each housing intervention type and emergency shelter.

1.1 Priority ranking on each list shall be done by VI-SPDAT/VI-F-SPDAT score, highest to lowest.

1.2 Privacy and security protections are consistent with those prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards.

1.3 Data collected from the assessment process will not discriminate or prioritize households from housing services on a protected basis, such as race, color, religion, national origin, sex, age, familial status, disability, actual
or perceived sexual orientation, gender identification or marital status.

2.) The Total Score will determine if a household will be prioritized to a housing intervention and to what type:

2.1 Individuals -

<table>
<thead>
<tr>
<th>Score</th>
<th>Housing Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 8</td>
<td>Permanent Supportive Housing</td>
</tr>
<tr>
<td>4-7</td>
<td>Rapid Re-Housing</td>
</tr>
<tr>
<td>4-7</td>
<td>Transitional Housing</td>
</tr>
<tr>
<td>4-7</td>
<td>Tenant-based Rental Assistance</td>
</tr>
<tr>
<td>&lt; 3</td>
<td>No Housing Intervention</td>
</tr>
</tbody>
</table>

2.2 Families -

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>&gt; 9</td>
<td>Permanent Supportive Housing</td>
</tr>
<tr>
<td>4-8</td>
<td>Rapid Re-Housing</td>
</tr>
<tr>
<td>4-8</td>
<td>Tenant Based Rental Assistance</td>
</tr>
<tr>
<td>&lt; 3</td>
<td>No Housing Intervention</td>
</tr>
</tbody>
</table>

2.3 Youth -

<table>
<thead>
<tr>
<th>Score</th>
<th>Housing Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 8</td>
<td>Permanent Supportive Housing</td>
</tr>
<tr>
<td>4-7</td>
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<td>Tenant-based Rental Assistance</td>
</tr>
<tr>
<td>&lt; 3</td>
<td>No Housing Intervention</td>
</tr>
</tbody>
</table>

3.) Referral for Permanent Supportive Housing

3.1 Prioritizing Chronically Homeless Persons in PSH Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

3.1.1 First Priority – This category consists of chronically homeless individuals and families with the longest history of homelessness and the most severe service needs (defined as the highest VI-SPDAT/VI-F-SPDAT score).

3.1.2 Should there be no chronic homeless individuals, referrals to PSH will be made by following the order of priority in Section 3.2.

3.2 Prioritizing Chronically Homeless Persons in PSH NOT Dedicated or NOT Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

3.2.1 First Priority–Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service
**Needs.** This category consists of an individual or family that is eligible for PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.

3.2.2 **Second Priority—Homeless Individuals and Families with a Disability with Severe Service Needs.** This category consists of an individual or family that is eligible for PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

3.2.3 **Third Priority—Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter without Severe Service Needs.** This category consists of an individual or family that is eligible for PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

3.2.4 **Fourth Priority—Homeless Individuals and Families with a Disability Coming from Transitional Housing.** This category consists of an individual or family that is eligible for PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing they had lived in a place not meant for human habitation, in an emergency shelter, or a safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

3.3 Referrals to PSH should follow the order of priority above while also considering the goals and any identified target populations served by the project to which the referral is being made.

3.4 While due diligence should be exercised when conducting outreach and assessment to ensure chronically homeless individuals and families are prioritized for assistance based on their total length of time homeless and/or the severity of their needs, PSH units should not be allowed to remain vacant indefinitely while waiting for an identified chronically homeless person to accept an offer of PSH. PSH units will only be allowed to remain vacant for 10 days. If the chronically homeless individual or family with the highest VI-SPDAT score is not located or does not respond within this period of time, the unit will be offered to the next highest ranked chronically homeless
individual or family.

3.5 A person experiencing chronic homelessness should not be forced to refuse an offer of PSH if they do not want to participate in the project’s services, nor should the PSH project have eligibility criteria or preconditions to entry that systematically exclude those with severe service needs.

3.6 Street outreach providers partnering with the centralized intake should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH. These chronically homeless persons must continue to be prioritized for PSH until they are housed.

3.7 If an individual and family with the same length of chronic homelessness, and VI-SPDAT score are prioritized for the same housing intervention, the family will be prioritized first due to the vulnerability of the children.

4.) Referral for Transitional Housing (TH)

4.1 Individuals and families who score highest for TH based on their VI-SPDAT/VI-F-SPDAT score AND meet at least one of the criteria listed below will be referred to TH:

4.1.1 Youth – non-disabled unaccompanied youth ages 16.5-24 without children.

4.1.2 Youth Parents – non-disabled youth ages 16.5-24 who are the parents of at least one child and are seeking assistance with that child(ren).

4.1.3 Veterans (choosing Grant and Per Diem - GPD)

5.) Referral for Rapid Rehousing (RRH) and Tenant-Based Rental Assistance (TBRA)

5.1 Individuals and families who score highest for RRH/TBRA based on their VI-SPDAT/VI-F-SPDAT score.

5.1.1 If an individual and/or family has the same VI-SPDAT/VI-F-SPDAT score, the one with the longest length of homelessness shall be prioritized first.

6.) Referral for Family Shelter

6.1 **First Priority** – Literally homeless, greatest vulnerability (living in a car or in a place not meant for human habitation).

6.1.1 If a family’s vulnerability is the same, in terms of their living situation, the family with the youngest children shall be prioritized first.

6.2 **Second Priority** – Literally homeless, highest VI-SPDAT score.

6.3 **Third Priority** – Imminent risk of homelessness, highest VI-SPDAT score.

6.4 Families in shelter but asked to leave due to rules violation shall be ranked at the bottom of the prioritization list.

7.) The Centralized Intake staff person will inform the individual or family of the type of housing intervention they are prioritized for and the program(s) within the intervention type including a general description of each (i.e., name of program, type and length of services and/or housing offered).
REFERRALS

POLICY:

1.) Referral protocols.
   1.1 Programs that participate in the CoC’s coordinated entry process accept all eligible referrals unless the CoC has a documented protocol for rejecting referrals that ensures that such rejections are justified and rare and that participants are able to identify and access another suitable project.
   1.2 Individual programs, including CoC funded projects, may restrict access to people with a particular disability or characteristic due to targeted population served. In these cases, the coordinated entry process should ensure that people are only referred to projects for which they are eligible.
   1.3 Providers should ensure that eligibility criteria are limited to those required by Federal or local statute or by funding sources.
      1.3.1 Providers limiting access due to specific client attributes or characteristics must provide documentation to the Coordinated Services Committee providing justification for their eligibility criteria.
      1.3.2 Providers offering Prevention and/or Short-Term Rapid Rehousing assistance (i.e., 0-6 months of financial assistance) may choose to apply some income standards for their enrollment determination.

2.) Person-Centered
   2.1 The coordinated entry process incorporates participant choice. Choice can include location and type of housing, level of services, and other options about which households can participate in decisions.

3.) Nondiscrimination
   3.1 When entering shelter, the CoC will ensure that emergency shelters, transitional housing and permanent housing (PSH and RRH) providers within the CoC do not deny admissions to or separate any family members from other members of their family based on race, color, religion, national origin, age, sexual orientation, gender identity, familial or marital status, disability, type or amount of disability or disability-related services or support required.
   3.2 The CoC’s CI referral process is informed by Federal, State, and local Fair Housing laws and regulations and ensures participants are not “steered” toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.

PROCEDURE:

Making Referrals
   1.) Referrals will be based on each program’s admission eligibility criteria, including populations served. Programs participating in the Centralized Intake shall submit their eligibility criteria to the Centralized Intake program manager. Any changes to a
program’s targeted population or eligibility criteria should be immediately conveyed to the Centralized Intake program manager.

2.) For households prioritized for a housing intervention, the centralize intake staff will describe how the referral process will work:
   a. Client choice, if more than one program, unit or location are available within the intervention category;
   b. If no units are available, placement on the priority list;
   c. How they will be contacted once a unit is open; and
   d. How much time they will have to respond and the consequences of not responding within the given time frame.

3.) For households not prioritized for a housing intervention, or who lack shelter while waiting for an opening, the Centralized Intake staff will describe the referral process for shelter:
   a. Options available for shelter, admission criteria and program requirements;
   b. Client choice, if more than one program available and eligible for both programs.
   c. If no units are available, placement on the priority list;
   d. How they will be contacted once a unit is open; and
   e. How much time they will have to respond and the consequences of not responding within the given time frame.

4.) When a unit, or bed in the case of shelter, becomes available, the program manager will select the household at the top of priority list for the respective housing intervention and notify them of the opening.
   a. In the case of shelter, if the household has not responded to the program manager within 6 hours, the slot will be made available to the next household on the priority list for shelter.
   b. In the case of a housing intervention, if the household has not responded to the program manager within 72 hours, the slot will be made available to the next household on the priority list for the particular housing intervention.

5.) The program manager will call the program with the opening and arrange a meeting time for the household. At this time, the program manager will also ensure:
   a. The household has the address and directions to the program to which they are being referred and have transportation to the program site. If not, the program manager will coordinate transportation for the household;
   b. The Initial Intake has been completed in ServicePoint;
   c. The VI-SPDAT has been completed in ServicePoint
   d. A homeless verification letter has been uploaded into the client’s HMIS file via SharePoint.

6.) The referred-to program should contact the program manager if the household fails to arrive within one hour following the scheduled meeting time. The program manager will attempt to contact the household but if the household does not respond within 12 hours, the slot will be made available to the next household on the priority list for
that housing intervention or shelter.
7.) Households not responding to the program manager’s phone calls, or not arriving for prearranged appointment with referred-to-program will remain on the priority list for 90 days. If no agency in the continuum has had contact with the household within 90 days the household will be removed from the priority list.
   a. All attempts at contact during the 90-day period will be documented in HMIS.
   b. If at some later date the household reengages with the centralized intake, a new intake and VI-SPDAT will be completed and the household will be prioritized accordingly on the appropriate housing list.

Referral Rejection Policy

Either CoC providers or program participants may deny or reject referrals from the Centralized Intake, although service denials should be infrequent and must be documented in the Initial Intake.

1.) Program Declines Referral
   1.1 Emergency shelters, transitional housing and permanent housing (PSH and RRH) providers within the CoC are prohibited from denying admission to or separating any family members from other members of their family based on age, sex, gender, disability when entering shelter and housing.
   1.2 All agencies must submit basic program denial criteria to the CoC for the use of Centralized Intake referrals.
   1.3 Denials are acceptable only in certain situations, including:
      • Client/household does not meet required criteria for program eligibility
      • Client/household safety concerns. The client’s/household’s health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
      • Client’s/household’s needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
      • Property management denial (include specific reason cited by property manager).
      • For emergency shelter for individuals/couples, the individual or couple is on the shelter’s ‘banned list” for previous program infractions.
   1.4 Clients would not be referred only in certain situations, including:
      • Program is at bed/unit/service capacity at time of referral.
      • For emergency family shelter, 12 months have not passed since the client/household exited the shelter.
   1.5 The program declining the referral should immediately contact the staff person who referred the client/household.
   1.6 The Centralized Intake Referral Denial Form (Provider) – Appendix C - should be completed within 24 hours by the program staff person denying the referral and returned by fax/email to the centralized intake program manager.
1.7 Provider will also complete the HMIS referral entry consistent with the established protocol.

1.8 The specific criteria for denying a referral must be shared with client/household.

1.9 If a program consistently refuses referrals (more than 25%, ) they must meet with the CI program manager and the Coordinated Services Committee to discuss the issue that is causing the refusals.

1.10 In instances where the client/household has been denied all available housing, shelter and/or services to which they’ve been referred due to failure to previously comply with program requirements, the client, Centralized Intake program manager and case manager making the referrals, and representatives of the Coordinated Services Committee shall meet to discuss the issue that is causing the refusals.

1.11 If a program refuses referrals (more than 25%), they must meet with the CI program manager and the Coordinated Services Committee to discuss the issue that is causing the refusals.

2.) Client/Household Refuses Referral

2.1 Denials are acceptable only in certain situations, including:

- Client/household refused further participation (or client moved out of CoC area)
- Client/household unresponsive to multiple communication attempts.
- Client/household resolved crisis without assistance.
- Client/household safety concerns. The client/household believes their health or wellbeing would be negatively impacted due to staffing or location.
- Client/household not satisfied with the location or type of housing offered.
- Client/household not satisfied with the level of services (either not enough or too stringent.
- The program declining the referral should immediately contact the centralized intake staff person who referred the client/household.

2.2 The Centralized Intake Referral Denial Form (Client) – Appendix D - should be completed immediately by the client/household declining the referral. If the client/household cannot be reached or refuses to complete the form, the CI staff person making the referral should complete the form noting the reason it is not being completed by the client/household.

2.3 The completed Centralized Intake Referral Denial Form (Clients) should be given to the centralized intake program manager within 24 hours.

2.4 A client who denies three sequential referrals will be required to participate in a case conferencing meeting with the centralized intake program manager and staff making the referral, and representatives of the Coordinated Services Committee to develop a housing plan.

Client and Provider Grievances

1.) Client Grievances
1.1 The Centralized Intake staff member working with the client/household should address any complaints by the client/household.

1.2 If the client’s/household’s complaint is not resolved, the client/household should be given the opportunity to speak to the centralized intake program manager.

1.3 Complaints that should be addressed by the CI staff member or program manager include:
   - How they were treated by the CI staff member
   - Physical conditions of the CI facility
   - Violation of confidentiality agreements.

1.4 All other complaints should be referred to the chair of the Coordinated Services Committee. This includes being denied admission to shelter, transitional or permanent housing or being separated from family members, based on age, sex, gender or disability.

   1.4.1 The CI program manager should forward, via email, a summary of the grievance to the chair of the Coordinated Services Committee.

   1.4.2 The committee chair should schedule the program manager and client/household to come to the next available Coordinated Services Committee meeting so the issue can be resolved.

   1.4.3 If the grievance needs more immediate resolution, the committee chair will be in charge of determining the best course of action to resolve the issue.

2.) Provider Grievances

2.1 The provider should contact the Centralized Intake program manager with any concerns about the CI process.

2.2 If the provider’s representative doesn’t feel like the concern has been resolved, they should forward, via email, a summary of their concern(s) to the chair of the Coordinated Services Committee.

2.3 The committee chair should schedule for the program manager and the provider’s representative to come to the next Coordinated Services Committee meeting so the issue can be resolved.

2.4 If the grievance needs more immediate resolution, the committee chair will be in charge of determining the best course of action to resolve the issue.

MONITORING SHELTER REFERRALS

POLICY:

1.) Housing First orientation
   1.1 The coordinated entry process is Housing First oriented, such that people are housed quickly.
PROCEDURE:
1.) To insure the shortest amount of time in shelter, shelter case managers and Centralized Intake staff will meet on a regular basis to conduct case reviews and pool knowledge about resources that may assist the household in exiting shelter as quickly as possible.
   1.1 These meeting will also provide a forum for shelter case managers to provide up to date information about pending bed availability and for centralized intake staff to update shelter case managers on the status of their client’s position on the housing intervention priority lists.

2.) Family shelter case managers and CI staff will meet at least two times per month.

3.) CISS case managers and CI staff will meet weekly.

4.) CFI domestic violence program staff and CI staff will meet monthly.

5.) IHYC youth program staff and CI staff will meet monthly.

DATA COLLECTION AND CLIENT CONFIDENTIALITY

POLICY:
1.) Using HMIS and other systems for coordinated entry.
   1.1 The CoC may use HMIS to collect and manage data associated with assessments and referrals or they may use another data system or process, particularly in instances where there is an existing system in place into which the coordinated entry process can be easily incorporated.

2.) Privacy Protections.
   2.1 Privacy protections are in place to ensure proper consent and use of client information.

PROCEDURE:
The Centralized Intake System will utilize proven software solutions that are currently built into the existing HMIS software for client intake and tracking requirements. The development of these tools and training of agency staff will be conducted by the Polk County Continuum of Care’s lead HMIS, Institute for Community Alliances (ICA).

Intake, Assessment and Prioritization Tools
1.) The initial intake, assessment, and prioritization tools, used in the centralized intake process shall be built into the HMIS. Centralized Intake staff shall utilize these tools to enter data as they are conducting the initial intake, assessment and prioritization for referral with the household.
2.) This will allow for the real-time evaluation of client needs, the electronic sharing of the intake and assessment information with the program/agency receiving the client placement and the creation of a comprehensive client record that will eliminate the need for clients to repeatedly be asked the same questions and will include the appropriate service and housing plan for the client household.

Data Entry Training
1.) All Centralized Intake staff as well as program/agency staff receiving client placements through the centralized intake system must be trained in utilizing all HMIS-based tools pertaining to their role in the Cl process. This shall include an initial training for existing and new staff as well as ongoing trainings as deemed necessary by HMIS lead.

2.) ICA will produce and provide all training materials on completion of the electronic intake, assessment and VI-SPDAT forms, use of the electronic referral tool, use of the bed registries and producing performance/outcome measurement reports.

Data Sharing and Confidentiality
1.) All Centralized Intake staff as well as program/agency staff receiving client placements through the centralized intake system will be required to comply with the User Confidentiality and Responsibility Certification – Appendix E - they signed at the time they were granted a license to use the HMIS.

2.) The sharing of data from the intake, assessment and VI-SPDAT tools will not only require client consent via a signed release of information (ROI) but also agency consent via a signed data sharing agreements (DSM) – Appendix F – Memorandum of Understanding to the program/agency receiving the client.

3.) The HMIS lead shall develop the appropriate memoranda of understanding and client release of information forms as well as train all partner agencies on the information in the documents and on their use as part of the centralized intake process.

4.) The Centralized Intake staff shall be responsible for reviewing with the client/household the ROI and explaining what data will be requested, how it will be shared, with whom it will be shared, and what the client’s/household’s rights are regarding the use of their data.

4.1 Centralized Intake staff shall be responsible for ensuring the client/household understands their rights as far as release of information and data confidentiality.

4.2 Clients/households should be offered a list of agencies in the sharing network.

5.) Regardless of whether the client/household signs the ROI, the Centralized Intake staff will begin the initial intake and assessment process.

5.1 When the ROI is not signed by the client/household, this will be noted in the intake and the client’s/household’s information will not be shared within the sharing network.
6.) A household will not be denied services if they decline to sign the ROI.
   6.1 However, it may take longer for the client/household to access the services since the assessment form will have to be filled out again by subsequent agencies from which the household is seeking assistance.

7.) Clients who want domestic violence-specific services should never be entered into HMIS. These include:
   7.1 A referral to CFI’s domestic violence program should be immediately completed. The client’s information may be entered into a HMIS-comparable database.

INFORMING LOCAL PLANNING

POLICY:
Information gathered through the Centralized Intake process is used to guide homeless assistance planning and system change efforts in the community.

PROCEDURE:
The designated operating agency of the Centralized Intake process, with assistance from the HMIS lead, shall report on performance objectives related to CI utilization, efficiency and effectiveness. Monthly, the following elements will be reported to the Continuum of Care Board by the Coordinated Services Committee:

   1.) Monthly narrative description of the status of the Centralized Intake’s implementation, barriers and challenges experienced as well as recommendations for expansion and improvements in the future.
   2.) A report, submitted quarterly, will include but not limited to the following
      • Number of families and individuals completing intakes
      • Number of families and individuals determined eligible for shelter and outcome of CI intervention (i.e. number entering shelter, number not entering shelter and reason for not entering shelter).
      • Number completing the diversion screen
      • Number completing the prevention screen
      • Number completing the VI-SPDAT/VI-FSPDAT/TAY-SPDAT
      • Number completing comprehensive assessment (families only)
      • Percent of declined referrals (provider)
      • Percent of declined referrals (consumer)
      • Number of complaints filed with Coordinated Service Committee (provider)
      • Number of complaints filed with Coordinated Services Committee (consumer)

   3.) Number of persons and individuals by VI-SPDAT score.

   4.) Number of persons and individuals receiving referrals to the following intervention types.
• Self-Resolve
• Permanent Supportive Housing
• Rapid Rehousing
• Tenant-Based Rental Assistance
• Transitional Housing
• Emergency shelter, families
• Emergency shelter, individuals

5.) Destination of persons and individuals to each of the following intervention types as a result of referral.
• Permanent Supportive Housing
• Rapid Rehousing
• Tenant-Based Rental Assistance
• Transitional Housing
• Emergency shelter, families
• Emergency shelter, individuals

6.) Semi-annually the length of time from completion of intake/assessment to program entry will report.
• Average length of time from intake/assessment to referral for each intervention type by family or individual.
• Average length of time waiting on prioritization list for each intervention type by family or individual.

7.) Semi-annually report the number of individuals and number of families who waited for each intervention type for greater than 30 days.

EVALUATION

POLICY:
1.) Ongoing planning and stakeholder consultation.
1.1 The CoC engages in ongoing planning with all stakeholders participating in the coordinated entry process to address the quality and effectiveness of the entire coordinated entry experience.
1.2 This planning includes evaluating and updating the coordinated entry process at least annually with feedback from each participating project and project participants.
1.3 Feedback from individuals and families experiencing homelessness or recently connected to housing through the coordinated entry process is regularly gathered through surveys, focus groups, and other means and is used to improve the process.
1.3.1 The CoC will ensure privacy protections for all participant information collected in the course of the annual coordinated entry evaluation.
PROCEDURE:
The Centralized Intake assessment process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily by the Coordinated Services Committee along with any consultants or third parties and reported to the Continuum of Care Board. Evaluation mechanisms will include the following:

1.) A quarterly review of performance measures for the Centralized Intake assessment process.

2.) A forum, hosted and convened by the Continuum of Care Board with people experiencing homelessness who have been through the coordinated assessment process will take place every six months. Sample questions to be used in these forums are in Appendix G.

3.) A report issued by the Continuum of Care to the community every six months on the centralized intake will consist of a month-to-month analysis of centralized intake data, as well as the total number of assessments and referrals made, successes to be shared, and system wide progress. Major findings from this report should be presented at the CoCB and HCC meetings the month it is released by the CoCB executive director. The CoCB executive director will assist in writing and producing this report. The contents of this report will be included in the annual report.

4.) An annual report on the homelessness assistance system with a section devoted to Centralized Intake. Within the annual report of the CoCB, there will be an overview of the Centralized Intake process, concerns and successes. Major findings from this annual report should be presented at the CoC and HCC meetings the month it is released by a member of the Coordinated Services Committee and/or CoCB executive director. The CoCB executive director will assist in writing and producing this report.
APPENDIX A

DES MOINES/POLK COUNTY RELEASE OF INFORMATION – INDIVIDUALS

DES MOINES/POLK COUNTY RELEASE OF INFORMATION - FAMILIES
Des Moines/Polk County Coordinated Intake Network
Client Informed Consent and Release of Information - INDIVIDUAL
Agency Name______________________________________________________________

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES
Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency participates in the Polk County Coordinated Intake Network. This network is administered by Primary Health Care, Inc. with technical services provided by the Institute for Community Alliances.

Because this Network is made up of many service providers in Polk County, you have the option to share your information with other service providers from whom you might be seeking services. Your identity, case manager information, incident history and information collected in the Polk County Coordinated Assessment will be shared, with your written consent, between collaborating agencies. The Polk County Coordinated Assessment includes your demographic information and other essential personal information needed to best determine your service needs. This process can benefit you by eliminating duplicate intakes, and may reduce the time spent answering basic questions regarding your situation, and allow that agency to focus on meeting your unique service needs.

The computer program used for this purpose has industry standard security protocols, and is updated regularly to meet these security standards. The information you provide will only be shared with this agency, the participating agencies in the Polk County Coordinated Intake Network, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department of the State of Iowa or the Federal Government. Information collected is housed in a secure server located at Bowman Internet Systems in Shreveport, Louisiana. Limited staff persons of Bowman Systems have access to this server and the data housed there and but only for network support and maintenance purposes. Data collected for the network will be maintained for seven years from the last date of service and then any inactive record will be permanently deleted from the network.

You will be provided with the list of participating providers in the Polk County Network for your review. This list may change, and the most up to date list can be obtained by request from this agency. The list can also be found at www.icalliances.org.

Please note; if you grant permission for your information to be shared, that agreement will be in effect for one year from the date of this form. If you do decide to share information at this time, but change your mind before the one year period has expired, you may end your agreement in writing and your personal and service information will no longer be shared from the date you end your permission going forward. If you do not give permission for this agency to release your information, no other service provision agency will have access to it.

___ Yes, I give my permission for this agency to share my information with the agencies participating in the Polk County Coordinated Intake Network. Please complete Page 2 of this document;

___ No, I do not give my permission for this agency to share my information with the agencies participating in the Polk County Coordinated Intake Network;

Client’s Printed Name__________________________________________________________________________
Client’s Signature ____________________________________________________________________________Date________
Witness Signature _____________________________________________________________________________Date________
Des Moines/Polk County Coordinated Intake Network Client
Informed Consent and Release of Information
Agency Name___________________________________________

Protected Health Information Release of Information to Secure Necessary Services Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement:

This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2): The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Par2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

As part of the process of being admitted to this program, you will be asked questions about disabilities or health conditions that you may or may not have. You will have the option to answer that you have the health condition, do not have the health condition, do not know, or refuse to answer.

My signature below directs the disclosure of the specific information listed below to the participating agencies of the Polk County Coordinated Intake Network as I have indicated here;
Please select “Yes” or “No” for the following question:

1. Regardless of whether or not you have any existing disabilities or health conditions, including but not limited to; HIV/AIDS, substance use, and mental health conditions, do you give us permission to share the information you tell us about these conditions with the Polk County Coordinated Intake Provider Network?

______ YES ______ NO

Client’s Printed Name ______________________________________________________________

Client’s Signature ______________________________________ Date ____________

Witness Signature _______________________________________________ Date __________
Des Moines/Polk County Coordinated Intake Network
Client Informed Consent and Release of Information – FAMILY
Agency Name

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES
Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency participates in the Polk County Coordinated Intake Network. This network is administered by Primary Health Care, Inc. with technical services provided by the Institute for Community Alliances.

Because this Network is made up of many service providers in Polk County, you have the option to share your information with other service providers from whom you might be seeking services. Your identity, case manager information, incident history and information collected in the Polk County Coordinated Assessment will be shared, with your written consent, between collaborating agencies. The Polk County Coordinated Assessment includes your demographic information and other essential personal information needed to best determine your service needs. This process can benefit you by eliminating duplicate intakes, and may reduce the time spent answering basic questions regarding your situation, and allow that agency to focus on meeting your unique service needs.

The computer program used for this purpose has industry standard security protocols, and is updated regularly to meet these security standards. The information you provide will only be shared with this agency, the participating agencies in the Polk County Coordinated Intake Network, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department the State of Iowa or the Federal Government. Information collected is housed in a secure server located at Bowman Internet Systems in Shreveport, Louisiana. Limited staff persons of Bowman Systems have access to this server and the data housed there and but only for network support and maintenance purposes. Data collected for the network will be maintained for seven years from the last date of service and then any inactive record will be permanently deleted from the network.

You will be provided with the list of participating providers in the Polk County Network for your review. This list may change, and the most up to date list can be obtained by request from this agency. The list can also be found at www.icalliances.org.

Please note; if you grant permission for your information to be shared, that agreement will be in effect for one year from the date of this form. If you do decide to share information at this time, but change your mind before the one year period has expired, you may end your agreement in writing and your personal and service information will no longer be shared from the date you end your permission going forward. If you do not give permission for this agency to release your information, no other service provision agency will have access to it.

___ Yes, I give my permission for this agency to share my information and my children’s information with the agencies participating in the Polk County Coordinated Intake Network. Please complete page 2 of this document.

___ No, I do not give my permission for this agency to share my or my children’s information with the agencies participating in the Polk County Coordinated Intake Network. Please complete the signature section at the top of page 2 of this document.
Protected Health Information Release of Information to Secure Necessary Services

Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement:

This information has been disclosed to you from records protected by the Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

As part of the process of being admitted to this program, you will be asked questions about disabilities or health conditions that you and your family members may or may not have. You will have the option to answer that you have the health condition, do not have the health condition, do not know, or refuse to answer.

My signature below directs the disclosure of the specific information listed below to the participating agencies of the Polk County Coordinated Intake Network as I have indicated here;

Please select “YES” or “NO” for the following question:

1. Regardless of whether or not you or your children have any existing disabilities or health conditions, including but not limited to; HIV/AIDS, substance use, and mental health conditions, do you give us permission to share the information you tell us about these conditions for you and your children with the Polk County Coordinated Intake Provider Network?

_____ YES   _____ NO
APPENDIX B

Participating Agencies
Polk County Coordinated Intake Network Participating Agencies

1. Anawim Housing, Inc., Des Moines, IA;

2. Broadlawns CAP Service Coordination, Des Moines, IA;

3. Catholic Charities, Des Moines, IA: St. Joseph’s Family Shelter;

4. Central Iowa Shelter & Services, Des Moines, IA;

5. Family Promise of Greater Des Moines, Des Moines, IA;

6. Hawthorn Hill, New Directions Shelter and Home Connection, Des Moines, IA

7. House of Mercy Permanent Supportive Housing, Des Moines, IA;

8. Iowa Homeless Youth, Lighthouse Transitional Living & Transitional Living programs, Des Moines, IA;

9. JOPPA, Des Moines, IA;

10. Primary Health Care, PATH Rapid ReHousing for Families & Supportive Services for Veteran Families programs, Des Moines, IA;

11. West Des Moines Human Services, West Des Moines, IA;

The Polk County Coordinated Intake Network utilizes a computerized record keeping system that captures information about people experiencing homelessness that is administered by the Institute for Community Alliances. This system allows programs if they agree, to share information electronically about clients, including their service needs, who have been entered into the software, in order to better coordinate services.

Client level information can only be shared between agencies that have established an Interagency Data Sharing Agreement and have received written consent from particular clients agreeing to share their personal information with another agency. The agency receiving the written consent has the ability to “share” that client’s information electronically through the system with a collaborating agency. This process can benefit clients by eliminating duplicate intakes. Intake and exit interviews can be shared, with written consent, between collaborating agencies.
APPENDIX C

CENTRALIZED INTAKE REFERRAL DENIAL FORM (PROVIDER)
Polk County Continuum of Care

Centralized Intake Referral Denial Form (Provider)

This form should be completed by the provider agency whenever they are denying a referral that has been made by a centralized intake staff person. Forms should be returned to the centralized intake program manager by fax/email within 24 hours of denial.

Referral Date:
Agency Name:
Program name: _____________________________________________________________

Staff contact: Email: Phone:

Client ServicePoint Number:

Reason for denial (please check a box, and you must explain in detail below)

☐ Client/household does not meet required criteria for program eligibility
☐ Client/household safety concerns. The client’s/household’s health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
☐ Client/household needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
☐ Program at bed/unit/service capacity at time of referral
☐ Property management denial (include specific reason cited by property manager)
☐ For emergency family shelter, 12 months have not passed since the client/household exited the shelter.
☐ For emergency shelter for individuals/couples, the individual or couple is on the shelter’s “banned list” for previous program infractions.

Please describe why you are unable to accept this referral.

Is this due to policy or procedure created by a funder, board, staff, property management, landlord or other entity?

Please explain:

If you feel this was an inappropriate referral, please indicate that below with an explanation.

Provider Staff Signature ____________________________ Date ____________
Polk County Continuum of Care

Coordinated Entry Referral Denial Form (Client)

This form should be completed by clients whenever they refuse a referral that has been made by a centralized intake staff person. Forms should be turned in to the centralized intake program manager within 24 hours of refusal.

Referral Date: 
Agency Name: 
Program name: 

Centralized Intake Staff person: 
Client ServicePoint Number: 

Reason for refusal (please check a box, and you must explain in detail below)

☐ Client/household refused further participation (or client moved out of CoC area)
☐ Client/household unresponsive to multiple communication attempts
☐ Client resolved crisis without assistance
☐ Client/household safety concerns. The client/household believes their health or wellbeing would be negatively impacted due to staffing or location.
☐ Client/household not satisfied with the location or type of housing offered.
☐ Client/household not satisfied with the level of services (either not enough or too stringent.
☐ The program declining the referral should immediately contact the centralized intake staff person who referred the client/household.

Please describe why you refused this referral.

If you feel this was an inappropriate referral, please indicate that below with an explanation.

Client Signature _____________________________ Date _____________ 
CI Staff Signature _____________________________ Date _____________
APPENDIX E

USER CONFIDENTIALITY AND RESPONSIBILITY CERTIFICATION
I-COUNT ServicePoint™ NETWORK
IOWA’S CONTINUUM OUTCOME AND UNIVERSAL NEED TOOLKIT USER
CONFIDENTIALITY AND RESPONSIBILITY CERTIFICATION
Iowa’s Homeless Information Management System

Provider Name: __________________________ Project Name: __________________________

Contract Fiscal Year: __________________________

USER CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT
Your User ID and Password give you access to the statewide ServicePoint™ software of the I-COUNT Network. Initial each item below to indicate your understanding and acceptance of the proper use of your User ID and password and your intention to comply with all elements of the Homeless Management Information System Data and Technical Standards Notice – published in the Federal Register on July 30, 2004 and revised July 2015 by the U.S. Department of Housing and Urban Development. Failure to uphold the confidentiality and security standards set forth below is grounds for immediate termination from the Iowa Homeless Information Management System and forfeiture of grant funds if applicable.

_______ An I-COUNT Network “Notice of Data Collection” sign will be posted at any location that client intake activity occurs that is entered or will be entered into the ServicePoint™ system.

_______ This agency has a written privacy policy that includes the allowable uses and disclosures of protected personal information by this agency and it will be made available to the client upon request.

_______ If applicable, this agency has their privacy policies posted on their agency internet website.

_______ My ServicePoint™ User ID and Password are for my use only and must not be shared with anyone, including coworkers within my own agency.

_______ I will take all reasonable means to keep my User ID and Password physically secure.

_______ I understand that the only individuals who can view information in the ServicePoint™ system are authorized users and the Clients to whom the information pertains.

_______ I may only view, obtain, disclose, or use the database information that is necessary to perform my job.

_______ If I am logged into ServicePoint™ and must leave the work area where the computer is located, I must log-off of ServicePoint before leaving the work area.

_______ I will attend any and all HMIS and related topic training sessions as required to ensure accurate and appropriate data entry and use of the I-COUNT Network.

_______ Any computer that has ServicePoint™ “open and running” shall never be left unattended.

_______ Any computer used to access ServicePoint™ must be located in a secure area that is not available for public access and use.

_______ Any computer that is used to access ServicePoint™ must be equipped with locking (password protected) screen savers.

_______ Any computer that is used to access ServicePoint™ must have virus protection software installed with auto-update functions.

_______ Any computer that is used to access ServicePoint™ must have software and/or hardware firewall protection.

_______ Failure to log off ServicePoint™ appropriately may result in a breach in client confidentiality and system security.

_______ Hard copies of Iowa ServicePoint information must be kept in a secure file.

_______ When hard copies of Iowa ServicePoint™ information are no longer needed, they must be properly destroyed to maintain confidentiality.

_______ If I notice or suspect a security breach, I must immediately notify the System Administrator - Institute for Community Alliances (ICA).

I understand and agree to comply with all the statements listed above. I further understand that at the time of program site visits conducted under the direction of Iowa Finance Authority or other applicable funder, our agency will be monitored for compliance with the I-COUNT Network management elements listed above.

________________________________________ __________________________
ServicePoint™ User (License Holder) Signature Date

________________________________________ __________________________
Agency Executive Director Date
APPENDIX F

POLK COUNTY DATA SHARING AGREEMENT
Polk County Coordinated Intake Network Memorandum of Understanding and Interagency Data Sharing & Coordinated Services Agreement

The following agencies hereby enter into an “Interagency Data Sharing and Coordinated Services Agreement” as of 12/2/16.

1. Anawim Housing, Inc., Des Moines, IA;
2. Beacon of Life, Des Moines, IA;
3. Broadlawns Medical Center, Des Moines, IA;
4. Catholic Charities, Des Moines, IA: St. Joseph’s Family Shelter;
5. Central Iowa Shelter & Services, Des Moines, IA;
6. Family Promise of Greater Des Moines, Des Moines, IA;
7. Hawthorn Hill, Des Moines, IA;
8. HOME, Inc., Des Moines, IA;
9. House of Mercy, Des Moines, IA;
10. Institute for Community Alliances (Network Technical Managers), Des Moines, IA;
11. JOPPA, Des Moines, IA;
12. Polk County General Assistance (Emergency Solutions Grant; ESG funding only), Des Moines, IA;
13. Polk County Health Services, Des Moines, IA;
14. Primary Health Care, Des Moines, IA;
15. VA Central Iowa Health Care System Community Resource & Referral Center (CRRC), Des Moines, IA;
16. West Des Moines Human Services, West Des Moines, IA;
17. YMCA Residential Housing Program, Des Moines, IA;
18. Youth and Shelter Services, Inc. - Iowa Homeless Youth Centers, Des Moines, IA;

The Polk County Coordinated Intake Network utilizes a computerized record keeping system that captures information about people experiencing homelessness that is administered by the Institute for Community Alliances. In addition to creating an unduplicated count of the homeless population and developing aggregate information that will assist in developing policies to end homelessness, the system allows programs if they agree, to share information electronically about clients, including their service needs, who have been entered into the software, in order to better coordinate services.

Client level information can only be shared between agencies that have established an Interagency Data Sharing Agreement and have received written consent from particular clients agreeing to share their personal information with another agency. The agency receiving the written consent has the ability to “share” that client’s information electronically through the system with a collaborating agency.

This process can benefit clients by eliminating duplicate intakes. Intake and exit interviews can
be shared, with written consent, between collaborating agencies. By establishing this agreement, the collaborating agencies agree that within the confines of the Polk County Coordinated Intake Network and the HMIS software:

1. Acknowledge that in transmitting, receiving, storing, processing or otherwise dealing with any consumer protected information, they are fully bound by state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (‘HIPAA’, 45 CFR, Parts 160 & 164), and cannot use or disclose the information except as permitted or required by this agreement or by law.

2. Acknowledge that they are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (‘HIPAA’, 45 CFR, Parts 160 & 164), A general authorization for the release of information is NOT sufficient for this purpose.

3. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

4. Agree to notify each of the other participating agencies, within one business day, of any breach, use, or disclosure of the protected information not provided for by this agreement.

5. Agree to adhere to the standards outlined within the Health Insurance Portability and Accountability Act of 1996 (‘HIPAA’, 45 CFR, Parts 160 & 164) which provides consumers access to their protected information, (164.524), the right to amend protected information (164.526), and receive an accounting of disclosures of protected information (164.528).

6. Information that is shared with written consent will not be used to harm or deny any services to a client.

7. The Agency shall not solicit or input information from Clients into the Coordinated Assessment database unless it is essential to provide services.
8. Clients have the right to request information about who has viewed or updated their Polk County Coordinated Intake Network record.

9. Agree to notify each of the other participating agencies of their intent to terminate their participation in this agreement.

10. Agree to resist, through judicial proceedings, any judicial or quasi-judicial effort to obtain access to protected information pertaining to consumers, unless expressly provided for in state and/or federal regulations.

11. Agree to complete the individual agency’s Authorization to Release Information in addition to the Polk County Coordinated Intake Network Release, if any protected personal information is released to any service provider outside of this coordinated service group as outlined above.

12. A violation of the above will result in immediate disciplinary action.

Whereby the above named agencies agree to share where applicable the following protected personal information via the Polk County Coordinated Intake Network (electronic, web-enabled):

- Client First Name
- Client Last Name
- Client Social Security Number
- Client Birth Date
- Entry/Exit Information
- Case Manager Information
- Incident History
- Client’s “Iowa Basic Assessment”
- Client’s Services History
- Client’s Program Goals
- Client Photo
- Client’s “Polk County Coordinated Assessment”
- Incident History
- Client’s “Vulnerability Index -Service Prioritization Decision Assistance Tool” (VI – SPDAT)

The signatures below constitute acceptance of the “Memorandum of Understanding” and “Data Sharing and Coordinated Services Agreement”:

Agency Name Street
Address City, State
Zip

Name & Title of Authorized Signature:

__________________________________________________________
Signature/Date
CONSUMER FORUM QUESTIONS

Sample Questions for Consumer Forums

1. Where did you first go for help when you became homeless?
2. How did you find out about that program or place?
3. What made you decide to go that place when you became homeless?
4. How did that place help you once they found out you were homeless?
5. Was this place easy for you to get to?
6. Would you recommend going to that place to someone else that became homeless? Why or why not?
7. If you needed a place to sleep that night, did you get it?
8. Did the person working with ask you questions? If so, did they explain why they were asking you questions?
9. Were you happy with what happened after they asked you questions?
10. Did the process make sense to you?
11. Did the process help you meet your housing needs?
12. Did you end up with somewhere to sleep that night?
13. Did you end up with a plan for getting back into permanent housing?
14. What other thoughts would you like to share with us?
APPENDIX H

COMMONLY USED TERMINOLOGY
COMMONLY USED TERMINOLOGY

Homeless – An individual or family is considered “homeless” if they meet the criteria in one of the four following categories:

Literally Homeless
(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
   (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
   (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
   (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Imminent Risk of Homelessness
(2) Individual or family who will imminently lose their primary nighttime residence, provided that:
   (i) Residence will be lost within 14 days of the date of application for homeless assistance;
   (ii) No subsequent residence has been identified; and
   (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Homeless under other Federal statutes
(3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
   (i) Are defined as homeless under the other listed federal statutes;
   (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
   (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
   (iii) Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing/ Attempting to Flee DV
(4) Any individual or family who:
   (i) Is fleeing, or is attempting to flee, domestic violence;
   (ii) Has no other residence; and
   (iii) Lacks the resources or support networks to obtain other permanent housing.
**Chronically Homeless** -

(1) A “homeless individual with a disability,” who:
   (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
   (ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

**Centralized or Coordinated Assessment System** - a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

- The goal is to increase efficiency of local crisis response systems and improve fairness and ease of access to resources, including mainstream resources.
- The system is intended to help communities prioritize people who are most in need of assistance.
- The system also provides CoCs and other stakeholders about service needs and gaps to help communities strategically allocate their current resources and identify the need for additional resources.

**Coordinated Entry or Coordinated Entry Process** – CoC and ESG Program interim rules use the terms “centralized or coordinated assessment” and “centralized or coordinated assessment system.” HUD and its Federal partners have begun using the terms “coordinated entry” and “coordinated entry process.” “Centralized or coordinated assessment system”
remains the legal term.

**Continuum of Care Programs (CoC Program)** – HUD funds that may be used to pay for costs used to establish and operate projects under five program components: permanent housing; transitional housing; supportive services only; HMIS; and, in some cases, homelessness prevention. Funds may be used for homelessness prevention only in High Performing Communities (HPC), since HUD only allows designated HPCs to carry out homelessness prevention activities through the CoC program.

**Coordinated Services Committee** – A standing committee of the Continuum of Care Board whose responsibilities include 1.) Developing a plan to coordinate and maintain a centralized intake system in Polk County; and 2.) Developing community strategies of improving service delivery, efficiencies and cost effectiveness in reducing homelessness.

**Diversion** – The use of community resources to divert from shelter an individual or family requesting shelter because they have no place to stay. Typically, diversion includes linking the person to community resources for child care, auto repairs, motel stay or mediation with a landlord, friend or family member so they can return to their previous living environment. Follow up typically occurs to assist the individual or family in developing a permanent housing plan.

**Emergency Shelter Emergency** - any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

**Emergency Solutions Grant (ESG)** – These HUD funds may be used for five program components: street outreach, emergency shelter, homelessness prevention, rapid re-housing assistance, and HMIS; as well as administrative activities.

**High Performing Communities (HPC)** - In order to qualify as an HPC, a Continuums must use their HMIS data to demonstrate the following measures:

1. That the mean length of homelessness must be less than 20 days for the Continuum’s geographic area, or the Continuum’s mean length of episodes for individuals and families in similar circumstances was reduced by at least 10 percent from the preceding year;
2. That less than 5 percent of individuals and families that leave homelessness become homeless again any time within the next 2 years, or the percentage of individuals and families in similar circumstances who became homeless again within 2 years after leaving homelessness was decreased by at least 20 percent from the preceding year; and
3. For Continuums of Care that served homeless families with youth defined as
homeless under other federal statutes, that 95 percent of those families did not become homeless again within a 2-year period following termination of assistance and that 85 percent of those families achieved independent living in permanent housing for at least 2 years following the termination of assistance.

**HMIS** - Homeless Management Information System (HMIS) means the information system designated by the Continuum of Care to comply with the HUD’s data collection, management, and reporting standards and used to collect client level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

**HMIS Lead** means the entity designated by the Continuum of Care to operate the Continuum’s HMIS on its behalf.

**HOME Investment Partnerships Program (HOME)** - provides formula grants to States and localities that communities use - often in partnership with local nonprofit groups - to fund a wide range of activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership or providing direct rental assistance to low-income people. HOME is the largest Federal block grant to state and local governments designed exclusively to create affordable housing for low-income households.

**Housing First** – a model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as sobriety or a minimum income threshold).

**Permanent Supportive Housing (PSH)** - permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently.

**Prevention** - The use of community resources to prevent an individual who is at imminent risk of losing housing (i.e. precariously housed and not yet homeless) from losing their housing. Typically, these community resources include legal assistance, landlord/tenant mediation and cash assistance to pay rent or utility arrears.

**Rapid Rehousing (RRH)** - housing assistance in the form of short-term (up to 3 months) and/or medium-term (for 3 to 24 months) tenant-based rental assistance, as necessary to help a homeless individual or family, with or without disabilities, move as quickly as possible into permanent housing and achieve stability in that housing. Supportive services may be provided as well.

**Safe Haven** - for the purpose of defining chronically homeless, supportive housing that
meets the following:

1. Serves hard to reach homeless persons with severe mental illness who came from the streets and have been unwilling or unable to participate in supportive services;
2. Provides 24-hour residence for eligible persons for an unspecified period;
3. Has an overnight capacity limited to 25 or fewer persons; and
4. Provides low-demand services and referrals for the residents.

**Tenant-Based Rental Assistance (TBRA)** - rental assistance in which program participants choose housing of an appropriate size in which to reside. In the Polk County CoC, TBRA is typically paid with HUD HOME funds passed through to the State of Iowa and administered by the Iowa Finance Authority (IFA). Typically, IFA holds an application round for HOME funds annually.

**Transitional Housing (TH)** - housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of homeless individuals and families into permanent housing within 24 months. Typically, TH targets special populations such as youth, pregnant women, Veterans, domestic violence victims and people with substance abuse and/or mental health issues. Services are also provide that are necessary to support the individual or family to successfully transition to permanent housing.

**VA Grant and Per Diem Program (GPD)** - allows community agencies to apply for grants from the VA to provide housing and other services (vocational assistance, case management, etc.) to encourage Veterans to learn the skills needed for them to achieve financial stability and independent housing.

**Veterans Affairs Supportive Housing (VASH)** - combines HUD Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics.